COUNTY OF LOS ANGELES
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

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Director

January 3, 2001

To: Supervisor Michael D. Antonovich, Mayor
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Supervisor Zev Yaroslavsky
Supervisor Don Knabe

From: Anita M. Bock
Director

RESPONSE TO CHILDREN'S SERVICES INSPECTOR GENERAL'S RECOMMENDATION OF OCTOBER 30, 2000

Pursuant to your Board's order of January 7, 1997, I am responding to the following recommendation of the Children's Services Inspector General:

Background

Some private hospitals have concerns regarding their ability to require families to remain at their facility when children are medically ready for release and have not been conclusively diagnosed as victims of abuse. Children who may possibly have been abused, and will be the subject of a hospital referral and DCFS investigation, are sometimes released to their parents and leave the hospital prior to the generation of the referral or the arrival of a DCFS Social Worker.

1. **DCFS should be ordered to investigate the problems surrounding detention of children at private hospitals, and attempt to develop procedures to ensure DCFS responds to hospital referrals and hospitals do not release children to parents prematurely (CSIG # 621).**

Response

DCFS agrees that communication between CSWs and private hospitals can be crucial in terms of obtaining a comprehensive assessment of risk to all children within the family. Policies/procedures now exist (Attachment I) which require response times and the Emergency Response (ER) CSW to consult with other agencies, community services and professions, as required, in order to

provide timely services and direct and coordinate all aspects of the intervention with the family.

Private hospitals are sometimes placed in the predicament of legally having to release children to their parents prior to the response of DCFS, because hospitals have not reported suspected abuse to the department immediately. In order to reduce these incidents, the new Bureau of Child Protection is developing an outreach program that will target hospitals, schools and other community agencies. The goal of this outreach program will be to educate mandated reporters about their legal responsibilities of reporting abuse as defined in penal code §11166, and detail protocol for them for reporting abuse. It is hoped that by providing this critical training, reports of abuse will be made more expeditiously, thereby allowing DCFS to intervene as quickly as possible. Additionally, DCFS will reinforce with our staff, through a "For Your Information" (FYI) bulletin, the necessity for a timely response. This bulletin will serve to highlight and remind staff of this significant risk assessment element.

Status: In progress:

Target date for completion: March 30, 2001

Please do not hesitate to call me if you have any questions, or your staff may contact Michelle Saulters at (213) 351-5787.

AMB:RD:dw

Attachment

c: Chief Administrative Officer
Children's Services Inspector General

DEPUTY DIRECTOR, BPP

DIRECTOR

RESPONSE TIMES

POLICY # CAP 1 (REVISED 09-92) **EFFECTIVE DATE: October, 1992**

FILING INSTRUCTIONS: File in CAP Handbook. This issuance replaces CAP 1 (Revised 10-91).

WIC 16501.1(a) and SDSS MPP 30-132.21 and .4 establish the State's standards for response times on all "accepted for response" referrals. DCS has established two time frames: Immediate Response and Within 5 Days. The operational definitions of these terms are in Part 1 of this release. The five-day time frame, which exceeds State requirements, was adopted on the basis of concern for child safety. DCS policy requires that response times be based on the level of suspected child endangerment and that CSWs initiate all responses at the first possible opportunity. SDSS MPP 30-132.3 establishes the standard for who must be seen at the initial response.

The revisions in this release are: a change in policy which will allow regional DCSAs and CAHL/ERCP SCSWs to downgrade IR referrals to Within 5 Days referrals, upon a finding that such a change will not endanger the referred child(ren); and, a change in the time frame during which Immediate Response (IR) referrals will be directed to regional offices. Effective immediately, IRs will be given to regional offices from 9:00 a.m. to 5:00 p.m.

A new form, the DCS 699, Authorization to Downgrade Response Time, is released by this issuance.

1. DEFINITIONS

A. *"Accepted for Response" Referral*

A referral which has been assessed by the Child Abuse Hot Line (CAHL), determined to require an in-person response, and referred to a CSW for action.

B. *Active Referral*

An "active referral" is an "accepted for response" referral (see definition) which has been transmitted (i.e., sent and received) by the CAHL to a regional office or the Emergency Response Command Post but not yet opened on CIS.

C. *Attempted Response*

If the CSW is unsuccessful in contacting all referred children and available parent(s)/guardian(s) in situations requiring an Immediate or Within 5 Days Response, the response is considered an attempted response.

D. *Baby Doe Referral*

A medical neglect referral which alleges that a viable but severely disabled infant is being denied appropriate medical care for a life-threatening condition. To fall within the Baby Doe category, the infant must be viable, i.e., (s)he could live if appropriate medical care was administered. If the infant is not viable and a physician has determined that extraordinary life-support treatment would be futile and should therefore be suspended, it is not a Baby Doe situation.

E. *Business Hours*

For the purposes of this release, business hours are from 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding County holidays.

F. *Closed Case*

"Closed case" means all DCS segments are terminated on CIS and WCMIS and the DCS case has been sent to storage.

G. *Completed Response*

In order for an Immediate or Within 5 Days Response to be considered completed, the CSW must have in-person contact with all referred children and available parent(s)/guardian(s) in situations requiring an Immediate or Within 5 Days Response.

H. *Erroneous Routing of a Referral*

For the purposes of this release, "erroneous routing of a referral" **refers only to a mapping error** (i.e., the address of the referred family is served by an office other than the one to which the referral was directed) on a referral on a new, terminated, or closed case (see definitions).

NOTE: There are situations in which a referral for an address which is not within the boundaries of a region may appropriately be directed to that region. **Example**: a family with an open case or active referral has moved to an address in another region, the case has not been transferred to the new region, and another referral on that family is received. The referral is directed to the case-carrying CSW in the original region. Such situations do not fall within the definition of erroneous routing.

I. *Immediate Response (IR)*

"Immediate" is the response time frame given to "accepted for response" referrals (see definition) which appear to describe imminent child endangerment.

"Immediate" means that the assigned CSW must initiate the response (see definition) at the first possible opportunity and no later than 5:00 p.m. on the same day the referral was received by the DCS CAHL.

Note: IRs assigned to an Emergency Response Command Post CSW must be initiated prior to the end of that CSW's shift.

J. *Initiate the Response*

The response is considered "initiated" when the CSW leaves his/her office (or field location) to have face-to-face contact with the referred child(ren) and available parents/guardians.

K. *New Case*

"New case" means there is no active record on CIS.

L. *Open Case*

"Open case" means the case is open on CIS.

M. *Police Hold*

A placement request referral from a law enforcement agency which has taken a child into custody.

N. *Terminated Case*

"Terminated case" means all DCS segments are terminated on CIS.

O. *Within 5 Days Response*

"Within 5 Days" is the response time frame given to "accepted for response" referrals (see definition) which appear to describe child endangerment which is not imminent. "Within 5 Days" means that the assigned CSW must initiate the response (see definition) at the first possible opportunity, and no later than 5:00 p.m. on the 5th *calendar* day following receipt of the referral, counting the day the referral was received by the DCS CAHL as day one. This category includes those referrals in which an immediate response is not required but a response is needed at a specified time prior to the 5th calendar day.

2. POLICY AND STANDARDS

A. It is this Department's policy that the protection and safety of a child is always the first priority.

B. Response times shall be determined on the basis of the level of suspected child endangerment and in compliance with SDSS requirements and DCS policy, specified in Part 2.D.1.- 4., below.

C. Initial designation of the appropriate response time is the responsibility of the Child Abuse Hot Line (CAHL) CSW. See Part 2.E., below, regarding downgrading of assigned response times.

There are two response times: Immediate and Within 5 Days. All "accepted for response" referrals (see definition) shall be designated as Immediate Responses (IRs) or Within 5 Days Responses (see definitions) according to the standards in this release.

D. In determining the appropriate response time, the CAHL CSW shall assess the content of the allegation in conjunction with other factors (described in Part 2.D.3., below) which may influence the outcome of DCS' intervention.

Certain categories of referrals always require an Immediate Response unless the CAHL CSW can document the immediate safety of the child. These categories are specified below. All other referrals in which a child is alleged to be the victim of abuse, neglect, or exploitation shall be carefully evaluated to determine whether they should be Immediate or Within 5 Days responses. All documentation shall be recorded on the CIS 100, Emergency Response Referral.

1. **IMMEDIATE RESPONSES**

   a. SDSS regulations require that the following referrals **always** be designated as IRs:

      1) a **law enforcement agency** refers a child who is at immediate risk of abuse, neglect, or exploitation (SDSS MPP 30-132.211); or,

      2) there is an indication of the existence of a situation which is likely to **imminently cause physical pain, injury, disability, severe emotional harm, or death** to a child (SDSS MPP 30-132.212).

   b. In addition to the referrals described in 1.a., above, DCS policy requires that, **unless the CAHL CSW can document the child's immediate safety, the following types of referrals are mandatory IRs:**

      1) situations in which the child's immediate safety is endangered;

      2) referrals on all children age birth to 48 months alleged to be the victims of abuse, neglect, or exploitation;

      3) reports of severe abuse or neglect (e.g., physical injury resulting in a bone fracture or neglect-linked failure-to-thrive);

      4) reports of sexual abuse (regardless of type) if suspected perpetrator has immediate access to the child victim;

      5) child age 10 years or younger alone at time of report;

      6) reports of a parent being psychotic, behaving bizarrely, or acting under the influence of drugs or alcohol and alleged to have harmed or threatened to harm the child;

      7) reports of bizarre punishment;

      8) reports of a child alleged to be the victim of abuse, neglect, or exploitation making a suicide attempt/suicidal gesture and the child is not hospitalized and there is no one taking appropriate action to protect the child;

      9) reports from a hospital emergency room that a child who is in the ER at the time of the report is the victim of non-accidental injury;

      10) requests from a parent that a child be removed and placed in order to prevent the parent hurting the child;

11) reports of physical abuse of a disabled child whose disability prevents self-protection;

12) reports of child abandonment;

13) Baby Doe referrals (see definition);

14) police holds (see definition);

15) situations in which the referred child/family may flee, making the child victim(s) unavailable for the in-person response;

16) minor child has died as the result of abuse or neglect and there are other minor child(ren) living in the home; and,

17) requests from hospitals for same-day placement of a child who is medically ready for discharge (and therefore ineligible for continued Medi-Cal funding for this hospital stay) **and** who is alleged to be the victim of abuse, neglect, or exploitation as defined by SDSS.

2. **WITHIN 5 DAYS**

"Accepted for response" (see definition) referrals shall be designated as Within 5 Days Responses when:

a. there is no indication of the existence of a situation which is likely to imminently cause physical pain, injury, disability, severe emotional harm, or death to a child; ***and***,

b. it is not described by the criteria for a mandatory IR, above; ***and***,

c. every effort has been made to ascertain from the referrer/ collateral contacts that it is reasonable to believe the referred child will be safe during the Within 5 Days time frame.

If there is a threat of specific harm which is <u>not immediate but which is expected to occur prior to the fifth calendar day</u>, the response shall be designated as Within 5 Days. The referral document shall contain a notation specifying when the expected endangerment will occur and establish the time frame for the in-person response.

3. **FACTORS TO CONSIDER IN DETERMINING RESPONSE TIME**

a. When a referral does not specifically describe a situation which is designated by SDSS regulations or DCS policy as a mandatory IR, the CAHL CSW must evaluate, based on his/her professional judgement, training and experience, the degree of risk to the referred child(ren). Based on that evaluation, the CAHL CSW shall designate the response time as Immediate or Within 5 Days.

b. Factors which shall be taken into consideration when assessing a referral to determine the appropriate response time include, but are not limited to, the following:

1) age and mental and physical capacities of the child;

2) severity and location of child's injuries;

3) recency and frequency of alleged incidents;

4) ability/willingness of the parent/guardian to cooperate with the CSW making the response;

5) support system/social isolation of the family;

6) when the allegation is physical/sexual abuse, the presence in the home of a stepfather, mother's boyfriend or other male parent substitute;

7) location of the child and the suspected perpetrator's access to the child;

8) physical condition of child's living environment;

9) existence of a current or imminent major family crisis;

10) existence of an opportune time/location to make the response;

11) multiple reports on the family;

12) child's statements regarding the situation;

13) known or suspected drug/alcohol abuse by the child's parent/guardian or other caregiver; and,

14) diagnosis of a medical condition *with linkage* to known or suspected abuse, neglect, or exploitation, e.g., failure-to-thrive, sexually-transmitted disease, spiral fracture, etc.

c. Special attention shall be paid to **certain combinations of risk factors** which have been shown to put children at high risk. Such combinations include, but are not limited to:

1) child is young and caregiver is psychotic

2) child is young and caregiver is developmentally delayed

3) child is young and caregiver is drug-involved

4) child is young and caregiver is socially isolated

5) child is young and medically fragile

4. RISK ASSESSMENT MATRIX

The risk assessment matrix on the following page shall be used to assist in structuring the response time decision. It describes 15 factors associated with child endangerment and the levels of risk associated with each factor.

The CAHL CSW shall weigh the various factors, taking into consideration the high-risk combinations described above and the individual circumstances of the referral which affect the risk to the child, and assign the response time accordingly.

SEE RISK ASSESSMENT MATRIX ON FOLLOWING PAGE

TEXT CONTINUES ON PAGE FOLLOWING MATRIX

ASSESSMENT MATRIX

FACTOR	a. LOW RISK	b. INTERMEDIATE RISK	c. HIGH RISK
1. Child's age, physical and mental abilities	10 years and over and cares for and protects self without or with limited adult assistance; no physical or mental handicaps/limitations	5 thru 9 years of age; any age requiring adult assistance to care for and protect self; emotionally withdrawn; minor physical illness/ mental handicap; mild to moderately impaired development	Less than 5 years of age; any age unable to care for or protect self without adult assistance; severe physical illness/ mental handicap; over-active; difficult or provocative; severely impaired development
2. Severity and/or frequency of abuse, physical or sexual	No injury or minor injury; not requiring medical attention; no discernible effect on child; isolated incident	Minor physical injury or unexplained injury requiring some form of medical treatment/diagnosis; history or pattern of punishment/discipline; mild sexual confrontation	Child requires immediate medical treatment and/or hospitalization; history or pattern of excessive punishment/discipline; sexual molestation
3. Severity and/or frequency of neglect and recentness	No discernible effect on child; isolated incident	Caretaker suspected of failing to meet minimum medical, food and/or shelter needs of child; unconfirmed history or pattern of leaving child unsupervised	Caretaker is unwilling to meet minimal medical, food and/or shelter needs of child; confirmed history or pattern of leaving child unsupervised or unprotected for excessive periods of time; child at severe risk of harm
4. Location of injury.	Bony body parts; knee, elbows, buttocks	Torso	Head, face or genitals
5. School problems	Regular attendance; no reported school problems	Frequent absences, some behavior problems, child comes unkempt and hungry	Severe behavior problems; parents uncooperative; child fearful of parental contact
6. Caretaker's physical, intellectual, or emotional abilities	No intellectual/physical limitations; realistic expectations of child; in full control of mental faculties	May be physically/emotionally handicapped; moderate intellectual limitations; past criminal/mental health record/history, poor reasoning abilities; needs planning assistance to protect child	Severely handicapped; poor perception of reality; unrealistic expectations/perceptions of child's behavior; severe intellectual limitations; incapacity due to alcohol/drug intoxication
7. Caretaker's level of cooperation	Willingness and ability to work with agency to resolve problem and protect child	Overly compliant with investigator; presence/ability of nonoffending adult to assure minimal cooperation with agency	Doesn't believe there is a problem; refuses to cooperate; uninterested or evasive
8. Caretaker's parenting skills and/or knowledge	Caretaker exhibits appropriate parenting skills and knowledge pertaining to child-rearing techniques or responsibilities	Inconsistent display of the necessary parenting skills and/or knowledge required to provide a minimal level of child care	Caretaker is unwilling/incapable of exercising the necessary parenting skills and/or lacks minimal knowledge needed to assure a minimal level of child care
9. Presence of a parent substitute in the home	Parent substitute in the home is viewed as supportive/stabilizing influence	Parent substitute is in the home on an infrequent basis and/or assumes only minimal caretaker responsibility for the child	Parent substitute resides with the family and is the alleged offender
10. Previous history of abuse/neglect	No previous reported history of abuse/neglect	Previous indicated report of abuse/ neglect; or protective services provided to the child, family or offender	Pending child abuse/neglect investigation; previous indicated abuse/neglect report of a serious nature; multiple reports of abuse/neglect involving the child, family or offender; prior dependency
11. Strength of family support systems	Family, neighbors, or friends available and committed to help; participation in church, community, or social group	Family supportive but not in geographic area; some support from friends and neighbors; limited community services available	Relatives or friends unavailable/uncommitted or subversive; geographically isolated from community services; no phone or means of transportation available
12. Perpetrator's access to child	Out of home, no access to child	In home, access to child is difficult; child is under constant supervision of other adult in the home	In home, complete access to child; uncertainty if other adult can protect child
13. Environmental condition of the home	Home is relatively clean with no apparent safety or health hazards; functional utilities	Trash and garbage not disposed and hazardous; water and/or electricity inoperative; infestation of ants, roaches or other vermin	Living in condemned and/or structurally unsound residence; exposed wiring and/or other potential fire/safety hazards present
14. Stresses/crises	Stable family; steady employment or income; means of transportation available; strong relationship with relatives	Pregnancy or recent birth of a child; insufficient income and/or food; inadequate home management skills/knowledge; relationship with relatives characterized by mutual hostility	Death of spouse; recent change in marital or relationship status; acute psychiatric episodes; spouse abuse/marital conflict; drug/alcohol dependency; chaotic life-style; criminal activity; frequent arrests
15. Substance abuse drug/alcohol	No drug/alcohol use; caretaker's drug/alcohol use does not influence parenting	Drug/alcohol use impairs caretaker functioning; connected to major presenting problem	Regular heavy use of drugs/ alcohol resulting in chronic endangerment to child; prevents working on case plan

E. Response time may be downgraded (i.e., changed from an IR to Within 5 Days) by a region only with the written approval of the SCSW and the signed authorization of the designated DCSA. In regional offices, authorization may not be delegated below the level of DCSA or acting DCSA.

Regions may downgrade an IR to Within 5 Days or to a specified time prior to the fifth day, provided that there is reasonable certainty that the referred child(ren) will not be at risk during that period of time.

Response time may be downgraded by the Emergency Response Command Post (ERCP) upon written approval of the ERCP SCSW and signed authorization of the ERCP DCSA. During the shift when there is no ERCP DCSA on duty, the ERCP SCSW and CAHL SCSW must agree on the downgrading. The CAHL SCSW will sign as the authorizing party.

ERCP may downgrade an IR only to Within 5 Days, provided that there is reasonable certainty that the referred child(ren) will not be at risk during the entire five day period. **ERCP may not downgrade to a specified time frame shorter than five days.**

Approval and authorization shall be obtained solely by means of the **DCS 699, Authorization to Downgrade Response Time.**

Response times may be upgraded (i.e., changed from Within 5 Days to an IR) without written approval or authorization, but the CAHL must be notified of the change.

F. All responses, whether IR or Within 5 Days, shall be initiated at the first possible opportunity.

1. On IRs, the CSW is expected to initiate the response (see definition) at the first possible opportunity, and no later than 5:00 p.m. on the same day the referral was received by the DCS CAHL.

   Note: IRs assigned to an Emergency Response Command Post CSW must be initiated prior to the end of that CSW's shift.

   It shall be standard practice that the CSW will not routinely wait until the end of the day to initiate the response if an earlier opportunity to do so is available. "Five o'clock of the same day the referral was received by the DCS CAHL" is *the outside limit*, not the goal.

   The assigned CSW will not transfer to the Emergency Response Command Post (ERCP) any referral which was assigned to the region prior to the ERCP cut-off time (5:00 p.m.), even if the cut-off time has passed before the CSW can initiate the IR.

   If the assigned CSW has not initiated the IR during his/her normal work hours, (s)he remains responsible for making the response.

2. On Within 5 Days Responses, the CSW is expected to initiate the response (see definition) at the first possible opportunity.

   It shall be standard practice that the CSW will not routinely let the five calendar day period elapse prior to initiating the response. "Five p.m. of the 5th calendar day, counting the day the referral was received by the DCS CAHL as day one" is *the outside limit*, not the goal. **The data**

on the CIS 100, Emergency Response Referral, shall be reviewed upon receipt to determine if any specific circumstances exist which would require the in-person response on or before a particular day (e.g., when an alleged perpetrator will have access to a referred child). In no instance shall the response be initiated later than 5:00 p.m. on the 5th calendar day, counting the day the referral was received by the DCS CAHL as day one.

Example

If a Within 5 Days referral is received by the DCS CAHL on a Thursday, the response must be made no later than 5:00 p.m. on the following Monday.

Note that responses on Within 5 Days referrals received by the DCS CAHL on a Tuesday or Wednesday must be made no later than 5:00 p.m. on Friday to meet the five calendar day limit.

G. When a new referral on an open case or active referral (see definitions) requires an in-person response and the case-carrying CSW will be unavailable to initiate the response within the assigned time frame, the SCSW shall assign another CSW to do so and ensure that it is done within the assigned time frame.

H. If the response was not *completed* (see definition), the CSW must decide if (s)he should make additional responses. This decision shall be based on whether or not a completed response is possible.

1. Examples of situations in which **additional responses shall be made** include but are not limited to:

   - child(ren) not available for interview at the time of the initial attempt and the CSW was unable to discover (e.g., by asking neighbors or relatives, checking with the local schools, etc.) any other location at which contact with the child(ren) could be made; or,

   - the CSW was denied entrance to the home (the CSW shall return to the home with law enforcement).

   When an additional attempt is appropriate, the CSW shall **initiate it within 24 hours (weekends and County holidays excluded)** of the conclusion of the prior attempt, with **allowance for an indefinite time frame based on the documentation of why it was not possible or reasonable to do so to meet the 24 hour** time frame.

   Acceptable reasons for exceeding this time limit shall be limited to situations in which it has been **determined that such an attempt would be futile**, e.g., when the CSW learns from a reliable source that the referred family is out-of-town and will not be returning within 24 hours. In such instances, the additional attempt must be initiated as soon as possible after the barrier to making the response has been eliminated.

2. Examples of situations in which **additional attempts need not be made** include but are not limited to:

- the address given does not exist and the CSW is unable to ascertain a valid address for the family; or,

- the referred family does not live at the address given and the CSW is unable to ascertain a valid address for the family.

CSWs shall make all reasonable efforts to locate the referred children, including, but not limited to, asking neighbors or relatives, checking with local schools and law enforcement agency, double-checking with the referrer, clearing DPSS records on WCMIS, etc.

I. The **date** and **time** of the **completed response** (see definition) and any **attempted response** (see definition), shall be documented on the **DCS 700, ER: Initial Response - Case Termination**, or the **DCS 701, ER: Initial Response - Assessment and Service Plan.**

Documentation regarding **why an additional attempt was not made** and/or **not initiated within 24 hours** (weekends and County holidays excluded) shall also be done on these forms. Documentation of an **attempted response** shall include the **reason** it was unsuccessful.

J. After a *completed* response (see definition), if there are any additional children in the family who were not subjects of the referral and who were not present at the time of the response, the decision to contact them is at the CSW's discretion *if all of the following conditions exist and the CSW believes that those children are safe and will remain so without in-person contact by the CSW:*

1. the CSW has had in-person contact with the child(ren) alleged to be abused, neglected, or exploited and all other children living in the home and present in the home at the time of the CSW's initial response;

2. the CSW has had in-person contact with the parent(s)/guardian(s) available at the time of the initial response; and,

   NOTE: Within this context, a parent or guardian is considered "available at the time of the initial response" if (s)he is physically present in Los Angeles County when the CSW is making the initial response.

3. the CSW has made the necessary collateral contacts with persons having knowledge of the condition of the children not seen.

If there is any doubt as to the safety of the additional children, the CSW shall also make an in-person response to see them as soon as possible.

This **decision** and the **reason(s)** for it shall be documented on the **DCS 700, ER: Initial Response - Case Termination**, or the **DCS 701, ER: Initial Response - Assessment and Service Plan.**

K. Erroneous routing (see definition) of **IR** referrals must be reported by the regional SCSW to the CAHL duty SCSW **as soon as possible, but no later than within 1 hour** of receipt of the referral by the region.

Erroneous routing (see definition) of **Within 5 Days** referrals must be reported by the regional SCSW to the CAHL duty SCSW within **four business hours** of receipt of the referral by the regional office.

If these time frames are not met, the receiving office must make the response and keep the case until ER services are completed and the case is terminated on CIS or program transferred.

L. CAHL and regional staff shall strictly adhere to all time frames set forth in this release.

3. PROCEDURES

A. CAHL REFERRAL TRANSMITTAL TIME FRAMES

1. **Immediate Response** referrals are reviewed by a CAHL SCSW immediately upon completion of the assessment by the CAHL CSW and transmitted (i.e., **sent and received**) to the regional office within 30 minutes of completion of the SCSW's review.

2. **Within 5 Days** referrals are transmitted (i.e., **sent and received**) to the regional office no later than two *business* hours after the CAHL CSW completes the assessment.

B. CUT-OFF TIME FOR IMMEDIATE RESPONSE (IR) AND POLICE HOLD REFERRALS TO REGIONAL OFFICES

IRs and police holds (see definition) will be assigned to regional offices until 5:00 p.m., i.e., the referral must be transmitted to and received by the regional office no later than 5:00 p.m. After 5:00 p.m., they will go to the Emergency Response Command Post (ERCP). This includes referrals on new, open, terminated, and closed cases (see definitions), and active referrals (see definition).

ERCP will take referrals until 9:00 a.m.

C. VERIFYING RECEIPT OF REFERRALS

1. IRs are verified by telephone by the CAHL within 10 minutes of transmittal to the region. If the referral was not received, a CAHL SCSW calls the receiving region and provides the referral data by telephone.

2. A verification list of all Within 5 Days referrals for the previous day is transmitted by the CAHL to each regional office every morning. It is to be reviewed and corrected (if needed) by the regional SCSW who was in charge of intake that day and returned by the regional office within **four business hours** of receipt.

   Upgrades of Within 5 Days referrals to IRs must be noted, per Part 3.E.2.

D. CORRECTING ERRONEOUS ROUTING OF REFERRALS

1. Erroneous routing (see definition) of an **IR** referral must be reported by the regional SCSW to the CAHL duty SCSW **as soon as possible, but no later than within 1 hour** of receipt of the referral by the region.

2. Erroneous routing (see definition) of a **Within 5 Days** referral must be reported by the regional SCSW to the CAHL duty SCSW within **four business hours** of receipt of the referral by the regional office.

3. **If these time frames are not met, the receiving office must make the response and keep the case until ER services are completed and the case is shown as terminated on CIS or program transferred.**

E. CHANGING THE ASSIGNED RESPONSE TIME

1. If the **regional CSW** wishes to **downgrade an IR to a Within 5 Days Response or to a specified time prior to the fifth day,** (s)he must obtain the **written approval of the SCSW and signed authorization of the designated DCSA or acting DCSA on the DCS 699, Authorization to Downgrade Response Time.**

   If the **ERCP CSW** wishes to **downgrade an IR to Within 5 Days,** (s)he must obtain the **written approval of the ERCP SCSW and signed authorization of the ERCP DCSA on the DCS 699.**

   EXCEPTION: During the shift when there is no ERCP DCSA on duty, the ERCP SCSW and CAHL SCSW must agree on the downgrading. The CAHL SCSW will sign the DCS 699 as the authorizing party.

   The specific circumstances which justify downgrading and the explanation of how it was ascertained that this change will not increase the risk of harm to the referred child(ren) must be documented on the DCS 699.

   The DCS 699 must be completed and faxed to the CAHL. In regional offices, this must be done no later than 6:00 p.m. of the same day the referral was received by the region. For ERCP staff, this must be done no later than one hour following the end of the work shift during which the change was authorized.

2. If the regional SCSW **upgrades a Within 5 Days Response to an IR,** (s)he must **note the upgrade on the verification list** which the CAHL will transmit to the region on the following day (see Part 3.C.2.).

3. **When a response time is changed, the CAHL and the regional office must update their respective copies of the CIS 100 to reflect the change.**

F. DOCUMENTING COMPLETED AND ATTEMPTED RESPONSES

The **date** and **time** of the **completed response** (see definition) and any **attempted response** (see definition) shall be documented on the:

DCS 700, ER: Initial Response - Case Termination, if no additional DCS services are required for any member of the family; or,

DCS 701, ER: Initial Response - Assessment and Service Plan, if additional DCS services are to be provided to any member of the family.

Documentation regarding why an additional attempt was not made and/or initiated within 24 hours (weekends and County holidays excluded) shall

also be done on these forms, in the **Recommendation** section of the **DCS 700** and the **Background** Section of the **DCS 701.**

Documentation of an **attempted response** shall also include the **reason** it was unsuccessful, using the following **reason codes:**

A - Address does not exist
B - Incorrect address
C - CSW denied entrance
D - Child(ren) not available for interview
E - Other (specify)

G. DOCUMENTING THE DECISION NOT TO SEE ADDITIONAL CHILDREN

1. The decision not to contact any additional children in the family who were not subjects of the referral and who were not present at the time of the CSW's initial response and the reason(s) for this decision shall be documented on the:

   a. **DCS 700, ER: Initial Response - Case Termination,** in the **Recommendation section** if no additional DCS services are required for any member of the family; or,

   b. **DCS 701, ER: Initial Response - Assessment and Service Plan,** in the **Background** section of the assessment portion, if additional DCS services are to be provided to any member of the family.

2. Children who were not seen by the CSW cannot be part of the service plan and may not be entered on CIS. If they have been entered on CIS, they must be terminated.

4. OTHER

None.

5. FORMS

A. FORMS REQUIRED

The following **new form** is required:

DCS 699, Authorization to Downgrade Response Time

B. FORMS CANCELLED/REVISED

1. The DCS 4, Emergency Response Assessment and Case Plan, is cancelled.

2. The DCS 1950-ER, Emergency Response Assessment and Case Plan, is cancelled.

AUTHORIZATION TO DOWNGRADE RESPONSE TIME

Case Name	**Case Number**
Date of Referral	**Date and Time Faxed to CAHL**

I hereby authorize the downgrading of the above-cited Immediate Response referral to a Within 5 Days Response referral, for the following reason(s) [describe the specific circumstances which justify downgrading the response time and explain how it was ascertained that this change will not increase the risk of harm to the referred child(ren)]:

Approved by (SCSW): **Date**

Authorized by (DCSA): **Date**

Distribution: **Original Filed With Referral in Case Record, Case Activity Recording Folder, left side**
Copy to Office DCS 699 File

INSTRUCTIONS FOR COMPLETION

1. Complete the referral identification data in the box.

   NOTE: In "Doe" cases, use "John Doe" or "Jane Doe" as the case name and also enter the parent's street address in the "Case Name" field.

2. Describe the specific reasons that the decision was made to downgrade the response time from Immediate to Within 5 Days and **why this change will not increase the risk of harm to the referred child(ren)**.

3. Complete the signature and date lines.

4. In a regional office, the DCS 699 is completed by the CSW/SCSW, approved by the SCSW, and authorized by the designated DCSA (or acting DCSA).

   In the Emergency Response Command Post (ERCP), the DCS 699 is completed by the ERCP CSW/SCSW, approved by the ERCP SCSW and authorized by the ERCP DCSA.

   EXCEPTION: During the shift when there is no ERCP DCSA on duty, the ERCP SCSW and the CAHL SCSW must agree on the downgrading. The CAHL SCSW will sign the DCS 699 as the authorizing party.

5. Regional staff must fax the DCS 699 to the Child Abuse Hot Line (CAHL) no later than 6:00 p.m. on the same day the referral was received by the region.

   ERCP staff must fax the DCS 699 to the CAHL no later than one hour following the end of the work shift during which the change was authorized.

6. This form is to be completed in duplicate. It may be handwritten or typewritten.

7. Distribute per instructions on front of form.

8. Each office shall maintain one centralized folder of all DCS 699s completed in that office.